

## Monthly news from the Scottish Public Services Ombudsman

This month we are laying six investigation reports about the health sector before the Scottish Parliament, and 60 decisions about all of the sectors under our remit. These can be read on our website at at [www.spsso.org.uk/our-findings](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (in August), we received 422 complaints. We determined 426 complaints and of these we

- gave advice on 218 complaints
- considered 142 complaints at our early resolution stage
- decided 66 complaints at our investigation stage.

We made a total of 97 recommendations.

## Ombudsman Overview



Today's reports provide learning across a range of NHS services – GP practices, care of the elderly, maternity services and surgery.

### Consent and communication in surgery

I highlighted the theme of consent last month, citing five different cases involving the need to improve the process for obtaining informed consent. One of today's reports (201405824) raises the issue again, in an investigation about a man who complained that he was not told in advance of surgery for other conditions that if polyps (small growths on the inner lining of the bowel) were found, they would be removed. I made two recommendations to address the inadequacy of the consent process. The first was that the board consider introducing pre-printed consent forms for common procedures such as the man underwent to ensure that the rare (but serious) complications of bowel perforation are not missed. The second recommendation aims to ensure that when an operation is transferred from one surgeon to another, it is clear to the operating surgeon that appropriate consent is in place.

In another of today's reports (201305461), two different hospitals were involved in treating a woman who underwent heart surgery and then a blood transfusion, and who died five days after the operation. I concluded that communication between the two hospitals should have been better given the woman's status as a high-risk patient with other pre-existing medical conditions and a history of previous heart surgery. Related to this, given her status and the complexity, her case should have been discussed at a pre-operative multi-disciplinary team meeting, which did not happen. In addition, my report notes that some documentation was not completed appropriately, particularly around consent for the procedure. I also agreed with independent advice I received that although a positive result from a swab was acted upon and antibiotics prescribed, it was not apparent that the potential relevance of this positive finding was fully realised by the cardiac team treating her, and whether consideration was given to potentially delaying the surgery in view of the risk of the subsequent sepsis.



## **GP practices: failures to use tools and guidelines; poor communication; missed diagnosis; unreasonable standards of care**

Two of today's reports involve failures by GP practices to use established tools and guidance to help them diagnose and treat patients. In one case (201404127), there was no evidence that GPs adequately investigated or examined an elderly man who was malnourished and losing weight. The man was in a unit that aims to rehabilitate patients for home, and his condition meant that he should have been assessed under the Malnutrition Universal Screening Tool. The GP practice also failed to take reasonable action when diagnoses of dehydration and possible urinary tract infection were made. This complaint involved wide-ranging failings, and, as well as making specific recommendations, I recommended that the practice carry out a further significant event analysis to address these.

In another case (201403542), a woman suffering hip pain was referred to orthopaedics and prescribed pain relief for suspected muscular pain. Her pain persisted, and she had reduced mobility and increased weight loss. There was an increased rate of contact with the practice, and many of the consultations were over the telephone. Almost two years after her first contact with the practice about her hip pain, she was found to have widespread secondary cancer to her hip and bone area. I accepted the independent advice I received that, given the patient's pattern of contact with the practice, her symptoms and abnormal test results should have led to a referral for an assessment for a potential underlying problem. Her rapid weight loss should have been investigated in line with guidelines for suspected cancer. In this case too, as well as specific recommendations, I asked the practice to discuss this complaint as a significant event.

## **Transfer arrangements; poor standard of maternity care**

In another of today's investigations (201403840), in which I found a poor standard of care had put a woman and her baby at unnecessary risk, the board had carried out a significant incident review following the original complaint. Their review did identify a number of failings in care, and recommended improvements at the maternity unit. However, I found inadequacies in their review, and made a number of recommendations to address failings including communication about transfers, care planning and handovers between staff.

## **Scottish Welfare Funds review consultation**

Earlier this month, we launched a consultation to help inform the way we will approach and manage reviews about welfare fund decisions. This is a new and different role for SPSO in relation to local authorities.

The consultation sets out a draft statement of practice, explaining how we will approach decision-making. We are also consulting on draft rules for oral hearings and on our approach to undertaking an Equalities and Human Rights Assessment of our new role.

**The full consultation can be found on our website**, and it is open until 27 November.

As well as our usual **Complaints Standards Authority** update, there is an update on a major **SPSO Conference** and forthcoming **training events**.

# Investigation Reports



Investigation report ref: 201405824

## **Hospitals; clinical treatment; diagnosis**

Highland NHS Board

### SUMMARY

Mr C complained to the board following treatment he received at Raigmore Hospital. He was admitted for a haemorrhoidectomy (surgery to remove haemorrhoids) and flexible sigmoidoscopy (a procedure to look inside the back passage and lower part of the large bowel). Polyps (small growths on the inner lining of the bowel) were found and removed during the sigmoidoscopy. Mr C was readmitted two days later, after experiencing considerable pain, and it was found that he needed emergency surgery for two holes in his bowel. Mr C said he was told that, if this second operation was not successful, he would need more surgery and a temporary colostomy bag. He said that the procedure caused him further pain, stress and anxiety.

Mr C said that he consented to surgery for haemorrhoids and to a flexible sigmoidoscopy on the understanding that the sigmoidoscopy was investigatory, and that he was not told polyps may be removed if identified. He said that, if he had known of the possibility of damage to his bowel, he may not have had the original procedure done. He was also concerned that, due to annual leave, the surgeon he had seen before his original day surgery did not perform the operation.

In investigating Mr C's complaints, my complaints reviewer obtained independent medical advice from a consultant colorectal surgeon who is experienced in carrying out the surgery Mr C had done.

My adviser noted that the board's response to Mr C's complaint said that the risk of bowel perforation from flexible sigmoidoscopy is low but increased with treatment for polyps. My adviser referred to General Medical Council guidance on consent which says that doctors must tell patients if an investigation or treatment could result in a serious adverse outcome. He said that, as the risk of perforation (and, therefore, a hospital admission) is a serious adverse outcome, not having discussed or made a record of such a discussion was unreasonable. He felt the question of whether polyps should have been removed was irrelevant as the consent process was inadequate.

Regarding Mr C's transfer from the care of the surgeon he had seen before his original day surgery to another surgeon, my adviser explained that it was the responsibility of the surgeon in charge of the case on the day to ensure that a procedure's risks had been explained. He said that the second surgeon should have ensured that the first surgeon had properly discussed the procedure with Mr C but the evidence did not show that this was done.

In light of the clear medical advice, I uphold the complaints and have made recommendations to the board.

# Investigation Reports



Investigation report ref: 201305461

**Hospitals; clinical treatment; diagnosis**

Lothian NHS Board

## SUMMARY

Mrs A was transferred from Victoria Hospital, Kirkcaldy, which is the responsibility of Fife NHS Board, to the Royal Infirmary of Edinburgh for heart surgery. Following one postponement in mid-December, the operation went ahead on 21 December 2012. Mrs A's niece (Mrs C) said that two days after the operation, her aunt was having a blood transfusion shortly after which she began to very rapidly decline. Mrs A was admitted to intensive care and died on 26 December 2012. The cause of Mrs A's death was recorded as multi-organ failure due to sepsis of unknown source in association with recent prosthetic aortic valve replacement and known ischaemic heart disease (a condition that affects the supply of blood to the heart). Mrs C complained that her aunt did not receive appropriate care and treatment from Lothian NHS Board.

In investigating this complaint, I took independent clinical advice from a cardiothoracic surgeon (specialising in chest, heart and lung surgery). The advice I received was that the heart surgery appeared to have been performed to a high standard, and Mrs A's initial recovery was good. Following a routine observation, Mrs A was recommended to have a blood transfusion. Her condition quickly deteriorated, and the board said that staff suspected a transfusion reaction and implemented their procedures for this. My adviser said that all teams reacted appropriately and promptly in response to Mrs A's condition.

Tests were taken to determine the cause of Mrs A's change in condition and I am satisfied that the blood Mrs A received was not contaminated. Her deterioration was coincidental with her developing a bacteria entering into her blood stream in association with sudden acute liver failure. However, I understand that it must have been very distressing for Mrs A's family to witness her sudden deterioration given the early signs that her heart surgery had been successful.

My investigation identified a number of areas that I am critical of. My adviser told me that communication between the two hospitals treating Mrs A should have been better given her status as a high-risk patient with other pre-existing medical conditions and a history of previous heart surgery. Related to this, given Mrs A's case was a high-risk and complex case, this should have been discussed at a pre-operative multi-disciplinary team meeting, which did not happen – the board said that when Mrs A was transferred to the Royal Infirmary she was fit for surgery and there were no alternative treatments to discuss.

My adviser noted that some documentation was not completed appropriately, particularly around consent for the procedure. Following Mrs A's death, there is no evidence that her GP was notified, as should have happened. I also acknowledge that there was an early retraction of Mrs A's death certificate which, according to my adviser, had been inappropriately completed by a junior doctor. I recognise the additional distress that this would have caused Mrs A's family.

Finally, during the course of my investigation I identified that there was a positive result from an umbilical (navel) swab taken on 12 December 2012, the day of the initial scheduled operation, which may have been the source of the subsequent bacteraemia (the presence of bacteria in the blood) and septicaemia responsible for Mrs A's death. My adviser said that although the positive result was acted upon and antibiotics prescribed to Mrs A, it is not apparent that the potential relevance of this positive finding for Mrs A, who was due to undergo high-risk re-do cardiac surgery, was fully realised by the cardiac team treating her and whether consideration was given to potentially delaying Mrs A's surgery in view of the risk of the subsequent sepsis.

I made a number of recommendations to address the failings I identified in the care and treatment provided to Mrs A. I also found that the board's handling of Mrs C's complaint was not reasonable. There were delays in responding which I accept the board have apologised for, but the apology letter was brief, lacked empathy and did not fully address the reasons for the delay. I note, however, that process changes have since been implemented so I have not made a recommendation about this.

# Investigation Reports



Investigation report ref: 201404127

## **GP & GP Practices; clinical treatment; diagnosis**

A Medical Practice in the Lothian NHS Board area

### SUMMARY

After suffering a stroke earlier in the year, Mr A was discharged from a hospital to a Step Down Unit in May 2014. This is a unit in a nursing home for elderly patients who are fit for discharge from hospital but need further rehabilitation before they can return home. Following a fall at the unit in early July 2014, Mr A's condition deteriorated. Over a number of weeks, he developed reduced mobility, reduced food intake and increasing pain. Mr A's daughter (Miss C) complained that, from the time of his fall until his readmission to hospital in early August, the care and treatment he received from GPs at his medical practice was unreasonable. She considered that Mr A should have been admitted to hospital earlier, and that it was unreasonable for a GP to suggest that one of the options was not to intervene, but to keep Mr A comfortable in the unit.

I took independent advice from one of my medical advisers who is a GP. The adviser had a number of concerns about the practice's failure to properly assess Mr A's condition. She said that the clinical records were sparse and lacked evidence of examination, of thorough clinical assessment, and of thorough assessment of Mr A's pain.

With regard to Mr A's food and fluid intake, she said that records showed that he lost 8.7 kilograms over a two-month period, or 16.5 percent of his body weight. This was a significant amount and she would have expected a GP to physically examine their patient to rule out any underlying cause for weight loss. She would also have expected a GP to have either made urgent arrangements for a dietician to assess the patient or to have provided simple food supplements until the dietician could attend. She noted that, under the Lothian Joint Formulary Guidelines, Mr A should have been given a MUST score ('Malnutrition Universal Screening Tool', British Association for Parenteral and Enteral Nutrition). As he had lost so much weight, he would have received the maximum MUST score, identifying the necessity of food supplements and regular monitoring.

It was thought that Mr A may have been suffering from dehydration and also possibly have a urine infection. The adviser considered that the care and treatment for these issues were not reasonable, as there was a delay in prescribing an antibiotic to treat the suspected urinary tract infection and the management plan to deal with the dehydration was not changed despite there being no improvement for weeks.

With regard to the GP's suggestion of not intervening but keeping Mr A comfortable in the unit, the adviser commented that the diagnosis of dehydration and a possible urinary tract infection were both easily treatable. She added that Mr A was malnourished and losing weight, yet there was no evidence of investigation or examination. The adviser said that the suggestion of not actively investigating or treating these potentially reversible conditions, in a patient in a unit that aims to rehabilitate patients for home, was not a reasonable standard of care.

My investigation found that the overall care provided to Mr A during the period following his fall until his readmission to hospital was not of a reasonable standard and so I upheld Miss C's complaint and made several recommendations.



# Investigation Reports



Investigation report ref: 201403542

## **GP & GP Practices; clinical treatment; diagnosis**

**A Medical Practice in the Tayside NHS Board area**

### SUMMARY

Mrs C complained about the care and treatment that her late mother-in-law (Mrs A) received from her medical practice over the two-year period before her death. Mrs A first contacted the practice in November 2011 about her hip pain. She was prescribed painkillers but the pain persisted, and an x-ray was taken in summer 2012 which suggested that she had osteoarthritis. Mrs A's pain increased so, in October 2012, the practice made a referral for her to see an orthopaedic consultant (who specialises in the musculoskeletal system).

In January 2013, Mrs A reported to the practice her weight loss of ten kilograms over two to three weeks. She saw the orthopaedic consultant, who thought that her pain was muscular and at the base of her spine, rather than caused by arthritis in her hip. Mrs A received physiotherapy and stronger painkillers, neither of which helped to reduce her worsening pain. She was re-referred to orthopaedics, and saw the consultant, who arranged a scan for the end of August 2013. Before the scan, Mrs A's condition deteriorated further. She was in regular contact with the practice, and prescribed different pain medications. She found the scan very painful and did not get the results in the time-frame she was expecting.

Mrs A's mobility decreased in September 2013 until she was mostly bed-bound, and a home visit from the practice was requested. The scan results showed an abnormality at the base of her spine and, in light of her deterioration, the practice arranged Mrs A's hospital admission. She was told soon after that she had widespread secondary cancer to her hip and pelvic bone area. She died in October 2013.

In investigating Mrs C's complaints, I obtained independent advice from a GP adviser. She was concerned that Mrs A's pattern of contact with the practice, her symptoms and abnormal test results should have led to a referral for an assessment for a potential underlying problem. The adviser said that Mrs A's rapid weight loss should have been investigated as it was unlikely to be only caused by nausea from her medication. The Scottish Referral Guidelines for Suspected Cancer say that unexplained or persistent weight loss of over three weeks should be referred for investigation, which did not happen. She also noted that Mrs A's haemoglobin level and liver function should have been rechecked after getting abnormal test results.

My adviser said that Mrs A's medical records showed her increased rate of contact with the practice during the two-year period before her death and, particularly, between July and September 2013. She said that the practice should have been alert to this pattern of contact. She also noted that over half of Mrs A's consultations in this period were over the telephone. She recognised the established place in patient care for telephone contact, but she felt the symptoms Mrs A described (increasing pain, reduced function and increased weight loss) meant that she needed clinical re-examination. She felt Mrs A's symptoms were sufficient for the practice to have considered an alternative diagnosis and further investigation.

In view of the clear medical advice I received about Mrs A's pattern of contact with the practice, her symptoms and her test results, I consider more could reasonably have been done by the practice to reassess her diagnosis and investigate other possible causes of her condition. I upheld this complaint and made several recommendations.

# Investigation Reports



Investigation report ref: 201403840

**Hospitals; clinical treatment; diagnosis**

Greater Glasgow and Clyde NHS Board

## SUMMARY

Ms C was assessed as low risk during her pregnancy and it was, therefore, considered suitable for her to deliver her baby at the Community Midwifery Unit at Vale of Leven District General Hospital. After going into labour she was admitted to the maternity unit but her labour was slow to progress. Several hours after admission, an examination found that her baby was in a posterior position (when the back of the baby's skull is in the back of the mother's pelvis). This meant that the delivery would be more complicated and would be likely to need a higher level of care than was available at the maternity unit. Staff called an ambulance to transfer Ms C to the Royal Alexandra Hospital. The ambulance service was particularly busy so the transfer took longer than expected. There was also a delay in the ambulance team accessing the building as they did not know the maternity unit. Ms C was given an episiotomy (a minor surgical cut that widens the opening of the vagina during childbirth) very shortly before she was transferred. Her baby was unwell at birth and she was transferred to another hospital for specialist neo-natal treatment.

Mr and Ms C complained to the board that the maternity unit did not reasonably explain in advance the transfer arrangements to hospital from the unit in case of an emergency; did not provide a reasonable standard of maternity care; delayed making the decision to transfer Ms C to hospital; contributed to delays during the transfer process; and that the board did not handle their complaint in line with the complaints procedure.

The board conducted a Significant Incident Review following the complaint, identifying a number of failings in Ms C's care, and recommending improvements at the maternity unit.

I took independent midwifery advice on this complaint. Regarding the information received about an emergency transfer to hospital from the maternity unit, it was clear that Ms C's understanding of the transport arrangements was not correct. She had also not been given any written information. The board acknowledged that Ms C should have been given clearer information, and they had amended a leaflet to include the transfer information. However, my adviser noted that the leaflet should be provided to women before they have chosen where to give birth.

We found several failures in the maternity care provided to Ms C in the maternity unit. This included a failure to properly assess her on admission or identify a clear plan of care; lack of monitoring throughout her labour; poor documentation, particularly of care planning and regarding handovers between staff; and also the episiotomy was undertaken inappropriately and possibly unnecessarily. The poor standard of care put Ms C and her baby at unnecessary risk.

As a result of some of the failures above, the decision to transfer Ms C to hospital was delayed. If her labour had been managed properly, she could have been transferred before it was an emergency. I am critical that the board's SIR did not highlight this delay and that they have yet to apologise for it.

The delay in the ambulance arriving at the maternity unit was due to pressures on the ambulance service and therefore out of the board's hands. However, the difficulties the crew experienced getting into the building were avoidable, and I am critical of the lack of action from the maternity unit staff.

The board clearly did not deal with Mr and Ms C's complaints within the timescales of their guidance (Guidance to Staff in Dealing with Complaints). Additionally, the board's final response to their complaints was in the form of notes from meetings, rather than a formal letter clearly stating whether complaints were upheld and providing a meaningful apology.

I upheld all of the complaints.

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# Complaints Standards Authority (CSA)



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## Local government

The next Local Authority Complaints Handlers network meeting will be held at the end of October in Glasgow. The network will feed back on the SPSO conference being held earlier in the month, specifically in relation to the themes of learning from complaints, quality assuring the complaints process and responses to complaints, and the self-assessment performance improvement framework. The meeting will also include a dedicated session on learning from complaints, with a view to producing guidelines to assist local authorities in implementing improvements identified from handling complaints.

We are aware that the majority of councils have now provided the Improvement Service with their 2014/15 annual complaints performance data for each of the SPSO indicators in a standardised way. The Improvement Service is currently in the process of analysing this data and will provide the headline findings at the October network meeting. This will enable members benchmark their performance against one another and to identify areas of good practice which can be shared across the sector.

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## NHS

Progress has been made in terms of the development of a revised NHS model complaints handling procedure (CHP), in line with one of the recommendations of the Scottish Health Council's Listening and Learning report. The Scottish Government's recently formed working group of NHS representatives met earlier in September to take forward the development. At this initial meeting the group considered what it is trying to achieve and the appropriate methodology to achieve this. In particular, the group discussed how best to engage with all stakeholders in the process, for example, independent contractors and service users, to ensure that the model CHP for the NHS meets everyone's requirements. The group also discussed the timescales for development, publication, testing and implementation of the model CHP.

It is expected that the working group will meet four times over the development phase of the model CHP. Dates of meetings will be communicated to working group members in due course.

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## Further Education

The Further Education Complaints Handling Advisory Group met most recently in September. Progress is being made in relation to developing standardised categories for complaints across the sector. Preliminary work has been completed by The City of Glasgow College to identify the various complaints categories currently being used across the sector. The Advisory Group agreed that the findings of this work should be used by a short-life working group to identify options for the introduction of standardised categories across the sector.



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# Complaints Standards Authority (CSA)

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## Further Education (continued)

The Advisory Group also considered how best to measure customer satisfaction with the complaints procedure. North East Scotland College has developed a questionnaire which asks complainants about their satisfaction with the service they received with regard to the complaints procedure, rather than the circumstances or outcome of their actual complaint. The Advisory Group agreed that this went a long way towards measuring satisfaction with the complaints handling service received, and will look at how they may incorporate a similar approach to measuring customer satisfaction.

Plans are in progress to organise a sector event for late November or early December to look at the annual complaints performance for colleges in 2014/15, and to consider wider good practice initiatives. Further updates will be issued by the Advisory Group when the date is finalised.

We would encourage any colleges that wish to join the Further Education Complaints Advisory Group to contact us at [CSA@spsso.org.uk](mailto:CSA@spsso.org.uk), and we will pass your details on to the Chair of the Group.

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## Housing

The next meeting of the Housing Complaints Handlers Network will be held in November. Dates and venue will be communicated by the network in due course.

Further information on the role of the network, including details of how you may join, can be obtained from [anne.fitzsimons@tollcross-ha.org.uk](mailto:anne.fitzsimons@tollcross-ha.org.uk).

For all previous updates, and for more information about CHPs, visit our dedicated website [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk).

## SPSO Training Events

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### SPSO Conference

We are delighted with the strong response to the first ever SPSO Conference on 'getting things right'. The conference and the waiting list are both full. We will put information including speaker presentations and workshop materials on our Valuing Complaints website after the 8 October event. There is a summary of the Conference themes below, and please contact [training@spsso.org.uk](mailto:training@spsso.org.uk) if you have any questions.

Complaints processes generally concentrate on 'putting it right' for the consumer. Using the intelligence that can be derived from complaints, how can we ensure we 'get it right' next time for everyone else? How do we ensure that our complaints processes and responses are fit for purpose and allow us to identify where there is learning and meet the needs of the consumer?

Keynote speakers from the SPSO and public and private sector organisations will talk about their real-world challenges in changing organisational culture, embedding potential learning and improving future practice. A series of workshops and ample networking opportunities will enable delegates to meet with colleagues across the public sector and beyond.

Booking now:

**Complaint investigation skills (stage 2 of the model CHP):** 1-day open course

Next course with spaces available: Wednesday 11 November, central Edinburgh

This is open to staff from all sectors under the SPSO's jurisdiction. **Full course details are available on the SPSO Training Unit website.**

For more information and to book spaces, please contact [training@spsso.org.uk](mailto:training@spsso.org.uk)

We have more information about courses that we can offer to organisations in our flyer:

**SPSO Training 2015 (PDF, 40KB)**

## Compliance and follow-up



In line with SPSO practice, my office will follow up with the organisations to ensure that they implement the actions to which they have agreed.

**Jim Martin, Ombudsman, 30 September 2015**

The compendium of reports can be found on our website: <http://www.spsso.org.uk/our-findings>

For further information please contact:

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## The Scottish Public Services Ombudsman



The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial and free**.

We are the final stage for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or writing to us, or filling out our online complaint form.

We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaints handling in bodies under our jurisdiction.



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